RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

NEW PATIENT INFORMATION FORM

For Referrals to Outpatient Therapy

LAST NAME | FIRST NAME | M.I

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE (HOME) | TELEPHONE (MOBILE) | SOCIAL SECURITY #

DATE OF BIRTH | GENDER | RACE | LANGUAGE

BIRTH PLACE

☐ CITIZEN
☐ RESIDENT
☐ UNDOCUMENTED

MOTHER'S MAIDEN NAME

MARITAL STATUS | NAME OF SPOUSE

EMERGENCY CONTACT NAME | RELATIONSHIP

ADDRESS | TELEPHONE NUMBER

INSURANCE:

☐ MEDI-CAL # | MEDI-CAL ISSUE DATE | ☐ MEDICARE #

☐ OTHER INSURANCE

Please return this form and the MD Referral form to:

Rancho Outpatient Referral Office
Telephone: (562) 401-6536 Fax: (562) 401-7604
Email: OutpatientTherapy@dhs.lacounty.gov (please send encrypted)